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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 8/2/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Lumbar Spine without Contrast CPT 72148

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐Upheld (Agree)

☒**Overturned (Disagree)**

☐Partially Overturned (Agree in part/Disagree in part)

The requested MRI of the Lumbar Spine without Contrast (CPT 72148) is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a male who sustained an industrial injury on XX/XX/XX. Injury occurred while he was XXXXX. He underwent decompression laminectomies and foraminotomies at L3/4 and L4/5, and discectomy left L4/5 on XX/XX/XX. He subsequently underwent L3, L4, and L5 laminectomies, with bilateral foraminotomies at L2/3, L3/4, L4/5 and L5/S1, L3/4 and L4/5 discectomy, and posterolateral instrumented fusion at L3 to L5 on 9/2/11. The XX/XX/XX lumbar spine magnetic resonance imaging (MRI) impression documented surgical changes at L3/4 and L4/5 with central bulging disc at L3/4 unchanged from X/X/XX. At L4/5, there was a 7 mm disc herniation extending central and to the right unchanged in appearance from X/XX/XX.

At L5/S1, there was a circumferential disc bulge associated with central canal stenosis. The XX/XX/XX electro-diagnostic study evidenced chronic left L4/5 radiculopathy with mild left peroneal motor mono-neuropathy. There was no evidence of sensory peripheral neuropathy. The XX/XX/XX lumbar spine computerized tomography (CT) scan impression documented prior wide laminectomy at L3 and L4 with posterior fusion L3-L5 and residual spondylosis. He underwent hardware removal with fusion exploration and bone graft on XX/XX/XX. The XX/XX/XX spine surgery report documented that the patient was released to work with some restrictions primarily on lifting. The XX/XX/XX spine surgery report indicated that the patient had returned to work on light duty. He reported that he had pain radiating down into his left leg with work activity and was dragging his leg by the end of the day. He reported intermittent decreased sensation. Physical exam documented 4/5 extensor hallucis longus and dorsiflexion weakness on the left. As the clinical exam showed weakness and the patient reported his symptoms were progressing, an MRI was recommended for further work up. At issue in this case is whether the requested service is medically necessary for treatment of the patient's medical condition.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) state that MRIs are test of choice for patients with prior back surgery. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neuro-compression, and recurrent disc herniation).

This patient presents with worsening low back pain radiating into his left leg with weakness and intermittent sensory deficits. He had returned to work light duty with an increase in pain and weakness. Clinical exam documented focal motor deficits on the left. He is status post 3 prior lumbar spine surgeries with the most recent MRI on XX/XX/XX, prior to the last surgery. Given the reported progressive weakness suggestive of nerve root compression, this request for repeat lumbar spine MRI is consistent with guidelines. Therefore, I have determined that this request is medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**